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ACCURATELY DIAGNOSING AND TREATING BORDERLINE PERSONALITY DISORDER: A Psychotherapeutic Case

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ABSTRACT

The high prevalence of comorbid bipolar and borderline personality disorders and some diagnostic criteria similar to both conditions present both diagnostic and therapeutic challenges. This article delineates certain symptoms which, by careful history taking, may be attributed more closely to one of these two disorders. Making the correct primary diagnosis along with comorbid psychiatric conditions and choosing the appropriate type of psychotherapy and pharmacotherapy are critical steps to a patient's recovery. In this article, we will use a case example to illustrate some of the challenges the psychiatrist may face in diagnosing and treating borderline personality disorder. In addition, we will explore treatment strategies, including various types of therapy modalities and medication classes, which may prove effective in stabilizing or reducing a broad range of symptomotology associated with borderline personality disorder.

INTRODUCTION

Borderline personality disorder (BPD) is a highly prevalent, chronic, and debilitating psychiatric problem characterized by a pattern of symptoms that may include chaotic and self-defeating interpersonal relationships, emotional lability, poor impulse control, angry outbursts, frequent suicidality, and self-

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TABLE 1. Diagnostic criteria for borderline personality disorder

A pervasive pattern of instability of interpersonal relationships, self image, and affects, and marked impulsivity beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:
1. Frantic efforts to avoid real or imagined abandonment. Note: Do not include suicidal or self-mutilating behavior covered in criterion 5.
2. A pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation
3. Identity disturbance: markedly and persistently unstable self image or sense of self
4. Impulsivity in at least two areas that are potentially self damaging (e.g., spending, sex, substance abuse, reckless driving, binge eating). Note: Do not include suicidal or self-mutilating behavior covered in Criterion 5.
5. Recurrent suicidal behavior, gestures, or threats, or self-mutilating behavior
6. Affective instability due to a marked reactivity of mood (e.g., intense episodic dysphoria, irritability, or anxiety usually lasting a few hours and only rarely more than a few days)
7. Chronic feelings of emptiness
8. Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights)
9. Transient, stress-related paranoid ideation or severe dissociative symptoms

American Psychiatric Association, *DSM-IV-TR*: 710[2]

mutilation.[1] It is not uncommon for the psychiatrist to see symptoms of both bipolar disorder (BD) and BPD, which creates a diagnostic dilemma that must be distinguished by the time of treatment initiation due to their diverging methods of approach. There are similar symptoms that may be seen in clinical presentations of both of these psychiatric disorders[2] (Tables 1–5).

The treatment of choice for BPD remains psychotherapy.[1] In this clinical vignette, the authors will review some of the common issues that present themselves as the psychiatrist navigates this often challenging professional relationship.

CLINICAL CASE

Brittany was a 22-year-old, single woman who presented for psychiatric consultation for ongoing management of BD.

Brittany was first diagnosed with BD as an unruly 16-year-old high school student. Subsequently, she had been seen by multiple psychiatrists for this disorder and had been prescribed multiple mood stabilizers, including gabapentin (Neurontin, Parke-Davis: Division of Pfizer Inc, New York), lamotrigine (Lamictal, GlaxoSmithKline, Research Triangle Park, North Carolina.), and valproic acid (Depakote, Abbott Laboratories, Abbott Park, Illinois). Most recently, she reported an overdose of valproic acid, which required a five-day stay in an intensive care unit; no subsequent inpatient psychiatric hospitalization was recommended. At the time of discharge, she assured the doctors that she was "fine," that "it was a stupid thing to do," and she verbally contracted that she would never try to overdose again.

During intake interview following the hospitalization, while she initially characterized her formative years as "good" with no report of any abuse, it became apparent that she had endured significant neglect from her parents, both of whom worked full-time to provide for the family.

Brittany described her symptoms of BD as starting at about the age of eight when she remembers it was necessary for her mother to seek full-time employment.

She remembered always having variable moods being "up and down," which were consistently correlated with multiple relational triggers in her life. As an example, she described being "manic" after a boy showed interest in her at school. Her 'manic' episode included increased energy and excitement, texting her friends up to a couple hundred times a day, shopping tirelessly to find the right outfit to wear for him, and noticing an increased sexual drive; her family members commented on her energetic behavior. When peers would tease her about being "easy" or she suspected her boyfriend was flirting with another classmate, she would seemingly lose control by yelling obscenities in an angry, uncontrolled rant.

These "manic" episodes could occur frequently (up to several times daily) depending on how many good things happened in her life and typically would last several hours at a time.

During the first interview, Brittany's speech was very rapid as she described her situation. The psychiatrist initially concluded that she was "pan-positive" on nearly every symptom of BD, but wanted additional time to consider possible axis II pathology. Psychotherapy had never been offered as part of the treatment recommendations; pharmacologic management had been the focus of her treatment thus far.

PRACTICE POINT

Diagnostic dilemma: BP versus BPD. BPD and BD, and particularly BD II, prove to be diagnostic dilemmas for practitioners due to the high occurrence of symptom overlap. Both disorders are associated with a considerable risk of suicide or suicide attempts, impulsivity, inappropriate anger, and unstable relationships.[3] However, many symptoms are particularly common in BPD to include self mutilation, self-injurious behavior without suicidal intent, and a stronger association to a childhood history of abuse. Insecure attachments, signified by an intense fear of abandonment, are hallmarks of BPD and not typical characteristics of BD.[3] Patients with BPD also demonstrate a higher level of impulsivity, hostility, and acute suicidal threats when compared to patients with BD.[3] Furthermore, Fiedorowwicz and Black[3] suggest careful history taking usually elicits a differing time course of mood lability: "Mood lability of BPD often is produced by interpersonal sensitivity, whereas mood lability in bipolar disorder tends to be autonomous and persistent."[3]

Widiger and Mullins-Sweatt[4] delineate a time course of BPD symptoms over a lifetime. Early in life, patients are likely to have been emotionally unstable, impulsive, and hostile, although, thus far, research has not clearly defined childhood antecedents of BPD.[4] Normal adolescence often involves rebellion or identity diffusion problems; however, the development and

TABLE 2. Criteria for major depressive episode

A. Five (or more) of the following symptoms have been present during the same two-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure. Note: Do not include symptoms that are clearly due to a general medical condition, or mood-incongruent delusions or hallucinations.
1. Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful). Note: In children and adolescents, can be irritable mood.
2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others)
3. Significant weight loss when not dieting or weight gain (e.g., a change of more than five percent of body weight in a month), or decrease or increase in appetite nearly every day. Note: In children, consider failure to make expected weight gains.
4. Insomnia or hypersomnia nearly every day
5. Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)
6. Fatigue or loss of energy nearly every day
7. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self reproach or guilt about being sick)
8. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)
9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide
B. The symptoms do not meet criteria for a mixed episode (Table 5).
C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
D. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism).
E. The symptoms are not better accounted for by bereavement, i.e., after the loss of a loved one, the symptoms persist for longer than two months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation.

American Psychiatric Association, *DSM-IV-TR*: 356[2]

TABLE 3. Criteria for manic episode

A. A distinct period of abnormally and persistently elevated, expansive, or irritable mood, lasting at least 1 week (or any duration if hospitalization is necessary).
B. During the period of mood disturbance, three (or more) of the following symptoms have persisted (four if the mood is only irritable) and have been present to a significant degree:
1. Inflated self esteem or grandiosity
2. Decreased need for sleep (e.g., feels rested after only three hours of sleep)
3. More talkative than usual or pressure to keep talking
4. Flight of ideas or subjective experience that thoughts are racing
5. Distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli)
6. Increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation
7. Excessive involvement in pleasurable activities that have a high potential for painful consequences (e.g., engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investments)
C. The symptoms do not meet criteria for a mixed episode (Table 5).
D. The mood disturbance is sufficiently severe to cause marked impairment in occupational functioning or in usual social activities or relationships with others, or to necessitate hospitalization to prevent harm to self or others, or there are psychotic features.
E. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication, or other treatment) or a general medical condition (e.g., hyperthyroidism).

Note: Manic-like episodes that are clearly caused by somatic antidepressant treatment (e.g., medication, electroconvulsive therapy, light therapy) should not count toward a diagnosis of bipolar I disorder.
American Psychiatric Association, *DSM-IV-TR*: 362.[2]

intensity of BPD traits in an adolescent may precipitate involvement in rebellious groups.[4] These maladaptive traits may also contribute to the development of various axis I disorders including post-traumatic stress disorder and other anxiety disorders, eating disorders, substance-related disorders, attention deficit hyperactivity disorder (ADHD), and mood disorders.[4,5,12]

As the patient with BPD enters adulthood, he or she she may be hospitalized multiple times due to his or her impairment in impulse control, suicidality and quasipsychotic and dissociative symptomotology.[4,5] Patients with BPD decompensations account for 20 percent of psychiatric hospitalizations.[6] Comorbid mood disorder and substance-related disorder increase the risk of suicide, and as many as 10 percent of patients with BPD will have completed suicide by the age of 30.[4] Employment history may be wrought with multiple job losses or career changes, and interpersonal relationships are continually volatile.[6] Fluctuations in gender identity, sexual orientation, and personal values may be common and likely stem from cognitive distortions and a fragmented sense of self.[6] Although a brief psychotic, dissociative, or mood disorder episode may recur, generally, by age 30, the patient's affective instability and impulsivity begins to lessen.[4] However, establishing a relationship with a supportive and patient sexual partner or simply retreating to a more isolated life may contribute to earlier stabilization of disruptive emotional lability.[4]

CLINICAL CASE, CONTINUED

Frequent and chronic feelings of depression were prevalent in Brittany's life. Many triggers in her life instigated a depressed mood, but there were also instances when no precipitant was identified. Sometimes her depressed mood came "out of the blue."

Additional historical information was collected during the first several psychotherapy sessions. She began reporting auditory hallucinations (hearing muffled voices calling her name) and visual hallucinations (seeing shadows) at age 12. She described one nonsuicidal self-injurious (NSSI) episode at the age of 13 when she scratched the word "alone" into her left forearm. She was subsequently very embarrassed about this as it forced her to wear long-sleeved shirts to hide it from others. She was very relieved when it healed completely, leaving no permanent scarring.

PRACTICE POINT

Treatment strategies for nonsuicidal self-injurious behavior in a psychotherapy setting. Acts of self harm may be suicidal or nonsuicidal, and both types are prevalent in BPD. It may be difficult for the psychiatrist to determine one from the other, as well as concluding the safest and least restrictive intervention to institute. The decision may be made to hospitalize the patient with nonsuicidal self harm since this behavior may be life threatening. If a patient is chronically suicidal, a

psychiatrist may underestimate the severity and forego the decision to hospitalize. A decision to hospitalize may greatly affect a therapeutic relationship in a psychotherapy setting, especially if the patient disagrees with the need for hospitalization.

There are no pharmacologic interventions that are known to be specifically effective in the case of self harm. Psychotherapy remains the intervention of choice for BPD, and there is now evidence that dialectical behavioral therapy (DBT) in particular is promising.[1,7–9]

DBT relies upon principles of both cognitive behavioral therapy (CBT) and zen Buddist meditative philosophy to help patients with BPD regulate their emotions by overcoming suffering through acceptance.[4] The treatment assumes that maladaptive behaviors, including self injury, are attempts to manage intense affect. DBT strategies initially focus on reducing self harm until treatment-disruptive behavior is mastered.[4] The focus of treatment then shifts to teaching coping skills for emotional control and interpersonal relatedness, which is facilitated by an individual therapist as well as didactic skills-training groups. DBT emphasizes validation of a patient's unbearably painful emotional experience along with acceptance that the patient is doing the best that he or she can at that moment.[4] The skills-training component focuses on mastery of four major areas: mindfulness, interpersonal effectiveness, distress tolerance, and emotion regulation.[10] Some specific therapeutic strategies include alternating between acceptance and change strategies, adding intuitive knowing to emotional experience and logical analysis, playing the devil's advocate, exploring new points of view, turning problems into assets, extending the seriousness of the patient's statements and advocating a middle path.[4]

Assessment of suicidality and NSSI behavior must be a top priority for the psychiatrist. Examples of NSSI behavior may include "deliberate, direct destruction of body tissue without conscious suicidal intent."[9] The most common forms of NSSI behavior in a study by Lloyd-Richardson et al[9] included biting self, cutting/carving skin, hitting self on purpose, and burning skin.

Stanley et al[7] studied NSSI behavior, including cutting or burning, which is the most frequent reason for psychiatric visits to medical emergency departments.[7] The neurophysiology and the clinical implications of NSSI behavior are

TABLE 4. Criteria for hypomanic episode

A. A distinct period of persistently elevated, expansive, or irritable mood, lasting throughout at least 4 days, that is clearly different from the usual nondepressed mood.
B. During the period of mood disturbance, three (or more) of the following symptoms have persisted (four if the mood is only irritable) and have been present to a significant degree:
1. Inflated self esteem or grandiosity
2. Decreased need for sleep (e.g., feels rested after only three hours of sleep)
3. More talkative than usual or pressure to keep talking
4. Flight of ideas or subjective experience that thoughts are racing
5. Distractibility (i.e., attention too easily drawn to unimportant or irrelevant external stimuli)
6. Increase in goal-directed activity (either socially, at work or school, or sexually) or psychomotor agitation
7. Excessive involvement in pleasurable activities that have a high potential for painful consequences (e.g., the person engages in unrestrained buying sprees, sexual indiscretions, or foolish business investments)
C. The episode is associated with an unequivocal change in functioning that is uncharacteristic of the person when not symptomatic.
D. The disturbance in mood and the change in functioning are observable by others.
E. The episode is not severe enough to cause marked impairment in social or occupational functioning, or to necessitate hospitalization, and there are no psychotic features.
F. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication, or other treatment) or a general medical condition (e.g., hyperthyroidism).

Note: Hypomanic-like episodes that are clearly caused by somatic antidepressant treatment (e.g., medication, electroconvulsive therapy, light therapy) should not count toward a diagnosis of Bipolar II Disorder. American Psychiatric Association, *DSM-IV-TR*: 368.[2]

TABLE 5. Criteria for mixed episode

A. The criteria are met both for a manic episode (Table 3) and for a major depressive episode (Table 2) (except for duration) nearly every day during at least a one-week period.
B. The mood disturbance is sufficiently severe to cause marked impairment in occupational functioning or in usual social activities or relationships with others, or to necessitate hospitalization to prevent harm to self or others, or there are psychotic features.
C. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication, or other treatment) or a general medical condition (e.g., hyperthyroidism).

Note: Mixed-like episodes that are clearly caused by somatic antidepressant treatment (e.g., medication, electroconvulsive therapy, light therapy) should not count toward a diagnosis of bipolar I disorder.
American Psychiatric Association, *DSM-IV-TR*: 365.[2]

TABLE 6. Patient selection for four therapies: psychodynamic, cognitive, interpersonal, and supportive

TYPE OF THERAPY	SELECTIVE PATIENT VARIABLES
Psychodynamic	• Chronic sense of emptiness and underestimation of self-worth • Loss or long separation in childhood • Conflicts in past relationships • Capacity for insight • Ability to modulate regression • Access to dreams and fantasy • Little need for direction and guidance • Stable environment
Cognitive	• Obvious distorted thoughts about self, world, and future • Pragmatic (logical) thinking • Real inadequacies (including poor responses to other psychotherapies) • Moderate to high need for direction and guidance • Responsiveness to behavioral training and self-help (high degree of self control)
Interpersonal	• Recent, focused dispute with spouse or significant other • Social or communication problems • Recent role transition or life change • Abnormal grief reaction • Modest to moderate need for direction and guidance • Responsiveness to environmental manipulation
Supportive	• Failure to progress in other types of therapy • Suicidal • Cognitively impaired and illogical • Acute or chronic medical illness • Presence of somatization or denial of illness • Requiring high levels of guidance or responsive to behavioral methods

Novalis, Rojcewicz, Peele. *Clinical Manual of Supportive Psychotherapy*, First Edition. Washington, DC: American Psychiatric Press, Inc.;1993:164.[11]

poorly understood, especially when there is no apparent suicidal intent. With a better understanding of the biological mechanisms involved in self injurious behavior (SIB), more effective pharmacologic regimens may be employed as well as accompanying psychotherapeutic interventions.[7] The NSSI group in the study by Stanley et al[7] had significantly lower levels of cerebrospinal fluid (CSF) beta-endorphin and met-enkephalin when compared with the non-NSSI group. Beta-endorphin is an opioid related to mediation of stress-induced analgesia; met-enkephalin is an opioid related to physical pain analgesia. Stanley et al[7] concluded that both opioids are thought to be involved in NSSI behavior; the severity of overall psychopathology was greater in the NSSI group. In this study, serotonergic and dopaminergic dysfunctions were not shown to have a relationship to NSSI behavior, but medications which act on the opioid system may still be implicated.

Nock et al[8] studied nonsuicidal- versus suicidal-related SIB in adolescents. Most of the adolescents assessed in this study were diagnosed with both axis I and axis II disorders, 62.9 and 67.3 percent, respectively. Overall, Nock et al[8] found that the vast majority of adolescents (70%) engaging in NSSI behavior reported a lifetime suicide attempt and more than half reported multiple attempts.[8] Some significant risk factors more closely associated with suicide attempts included a longer history of NSSI behavior, use of a greater number of methods, and absence of physical pain during NSSI behavior.[8]

Lloyd-Richardson et al[9] assessed the prevalence, associated clinical characteristics, and functions of NSSI behavior in a community sample of adolescents. This study found that the most common explanations for NSSI behavior were "to try to get a reaction from someone," "to get control of a situation," and "to stop bad feelings."[9] The study found that adolescents in this community

sample typically conducted the NSSI behaviors to influence behavior of others and to manage internal emotions. The psychiatrist working with patients who exhibit self harm should explore the etiology and antecedents of NSSI behavior and then institute as a goal of psychotherapy the reduction of these to the extent that is possible. The goals of the psychotherapy should also include building alternative coping strategies, increasing communication with the significant people in the patient's life, and building on the patient's social support system.[9]

CLINICAL CASE, CONTINUED

Brittany reported chronic feelings of emptiness as well as worry that her loved ones would abandon her. She mentioned in a psychotherapy session an intense fear that a family member might even be taken from her by severe illness, such as influenza A (H1N1).

She had chronic thoughts of not wanting to be alive anymore and even hoped that she might be involved in a motor vehicle accident to end the "constant pain." She had frequent thoughts of cutting herself to relieve her emotional pain, but fears of scarring prevented her from doing this.

Brittany occasionally heard muffled voices at times of maximal stress. These voices were always self deprecating, calling her fat, ugly, and stupid. Removing herself from stressful situations and being quiet helped calm the muffled voices.

Brittany: My bipolar is really out of control and none of the medications seem to work. My mood swings are all over the place and all I can think about is dying to end this misery. Doctors never help and always leave me when I need them the most. You're the only one who really understands me.

Psychiatrist: It seems as though you've felt misunderstood and unable to find the help you need.

Brittany: Yes, I know I have bipolar disorder, everyone in my family has it, but my case manager asked me if I've ever been told I have borderline personality disorder. What do you think?

Psychiatrist: You've had a difficult, unpredictable childhood and because of that you've learned to deal with problems as best you can. However, the intense way in which you experience emotions sometimes causes you to react in ways that show others how impossible, hopeless, and painful your life seems at times.

Brittany: That may be true, but I seem to only drive people away. They are always leaving me and you probably will too. The hospital is the only place I've ever felt safe and cared for. If only someone who knew what they were doing could get my bipolar under control, then I wouldn't have to live like this anymore!

Psychiatrist: Medications can be helpful; however, psychotherapy is the most important treatment for you. Would you be willing to discuss these frustrations on a weekly basis with me? Together, we could explore ways of coping that will give you the ability to better control how you experience your emotions and ultimately find the satisfaction you long for in relationships.

PRACTICE POINT

Making the diagnosis and choosing the type of psychotherapy. To arrive at an accurate diagnosis, information about presenting symptoms, past medical and psychiatric history, psychosocial history, current relationships, psychological functioning, and coping skills should be collected. Based on this information and other pertinent factors, a plan for treatment will be established.[11]

Marcinko et al[1] found that it is very important to evaluate possible comorbidity in diagnostic assessment of suicidal patients. The high prevalence of comorbid BD and BPD and some diagnostic criteria seen in both conditions present both a diagnostic and a therapeutic challenge. While pharmacotherapy is appropriate for the treatment of many psychiatric disorders, psychotherapy remains the treatment of choice for BPD. As mood stabilizers have been beneficial in the treatment of some patients with BPD, increasing attention has been given to the overlap between BPD and bipolar II disorder.[12] Although some individuals may present with BPD and comorbid BD, the majority of the evidence to date supports BPD as an independent diagnosis rather than an attenuated form of a mood disorder.[12] Furthermore, because of heterogeneity of the BPD, pharmacologic treatment has evolved to some particular dimensions of the BPD rather than the disorder in its entirety. The dimensions include affective instability, impulsive aggression, and identity disturbance. Effective medication management reduces the overall suffering of the patient and enables psychiatrists to make greater use of psychotherapeutic interventions, which are very important for BPD patients with and without BD comorbidity.

Although some individuals may present with BPD and comorbid BD, the majority of the evidence to date supports BPD as an independent diagnosis rather than an attenuated form of a mood disorder.[12]

Choice of medications for patients with BPD is largely based upon the predominant axis I symptomotology, which may include anxiety, depression, hallucinations, delusions, and dissociation.[4] However, it is important to consider that transient

symptoms are common in the course of BPD recovery, especially in the context of often unrelenting crises. As such, pharmacologic treatment should not be disproportionately influenced by symptoms stemming primarily from the axis II diagnosis.[4] Widiger and Mullins-Sweatt[4] recommend that exploratory or supportive techniques should be utilized first in managing these symptoms. Conversely, unnecessary resistance to use of medications and relying excessively upon the psychiatrist's own psychotherapeutic skills may extend periods of decompensation and cause more extensive suffering for the patient.[4]

The type of psychotherapy chosen is very important to the patient's success. Psychodynamic psychotherapy is appropriate for the patient with the capacity for insight, the ability to modulate regression, and is in a stable environment.[11] For the patient with pragmatic thinking, a high degree of self control, and the need for direction and guidance, Novalis et al[11] recommends cognitive therapy. Finally, the patient with failure to progress in other types of therapies, who has real inadequacies, or who requires high levels of guidance (as in the case of an acute stressor) may be well suited for supportive psychotherapy.[11] It may be appropriate to change the type of therapy from time to time during treatment in the event that the acute needs of the patient are altered (Table 6).

Often patients with BPD will report initial, middle, and/or late insomnia. Plante et al[13] found that sleep disturbance is a common, yet poorly understood, phenomenon in BPD. Sedative-hypnotic medications were studied in patients with BPD and were used significantly more often for insomnia both as scheduled medications and "as needed" when compared to all other personality disorders. In fact, patients with BPD were four times more likely to use these medications. Plante et al[13] concluded that subjective sleep disturbance is a significant problem in BPD.[13]

Binks et al[14] completed a pharmacology study regarding treatment of BPD. BPD was found to be prevalent (2% in the general population, 20% among psychiatry in-patients) and has a significant impact on the healthcare delivery system; a complicating factor is that the patients will have frequent and recurrent crisis situations but are often nonadherent with recommended treatment options.[14] The current information available from Binks's literature review indicates that the use of antidepressants may have a considerable positive effect in most patients.

Binks et al[15] also reviewed studies of psychological interventions and their success in patients with BPD. The definition of psychological treatments in this study included behavioral, cognitive-behavioral, psychodynamic, and psychoanalytic psychotherapies. After reviewing seven studies, Binks et al found that with DBT, some behaviors (including self harm or parasuicide) may decrease at 6 to 12 months, but there was no clear difference in hospital admissions. Another study showed a statistically significant decrease in suicidal ideation at six months for those receiving DBT.[15] Binks et al found no differences for outcomes of anxiety and depression, but those patients receiving DBT had milder symptoms than those in control groups. In summary, this review suggested that some of the problems frequently encountered by people with BPD may be amenable to psychotherapy and other behavioral treatments, especially when giving an extended course of treatment.[15]

CLINICAL CASE, CONTINUED

The course of treatment recommended at the end of the initial consultation was to begin psychotherapy (the treatment of choice for BPD) and initiate citalopram to address the many symptoms associated with the BPD. A slow taper of lamotrigine (Lamictal) over the course of the next several months was also planned, while continuing the full dose for the first six weeks while citalopram reached full therapeutic effect.

Over the next several weeks, Brittany agreed to adhere to medication recommendations and also engage in weekly psychotherapy sessions with her psychiatrist. Additional history revealed that Brittany had maintained a very chaotic relationship pattern throughout her early adulthood. She quickly developed feelings of attraction and dependency with multiple sexual partners. Though most partners found her sociable, supportive, and engaging, her low threshold for controlling her rage in common conflicts and disagreements typically evolved into abuse and ultimately abandonment. Moreover, her friends were frequently overwhelmed and annoyed by her intense feelings of hurt, anger, and depression. Brittany was, in turn, frequently deeply disappointed when her extreme reactions were not met with a consoling gesture.

Brittany: So I won't be able to see you while you're away next month?

Psychiatrist: No, but you will be able to contact the clinic in the case of an emergency. I will return for our regular session the following week.

Brittany: What if the other doctor doesn't understand me like you do? Can I call you if I'm having a hard time?! I knew you'd eventually leave me like everyone else has! You're a liar!

PRACTICE POINT

Abandonment issues processed from early developmental years and their persistence/significance in current relationships (including the psychiatrist in the room). According to Delgado and Songer,[5] absolute and unconditional love represents the core desire of patients with BPD. When others, including the psychiatrist, fail to embody these fantasies, affective storms may

abound as they develop extreme hatred toward the imperfect person.[5] With an understanding of the patient's early childhood experiences and family environment, the psychiatrist is able to interpret how these experiences have contributed to the development of the patient's maladaptive coping style and its impact in relationships. A deficit in the capacity to recognize and tolerate loving and hostile feelings toward the same person simultaneously (object constancy) constitutes the foundation for his or her constant fear of abandonment. As a result, the patient persistently employs primitive or immature defense mechanisms (e.g. splitting, projection, acting out, dissociation). A therapeutic alliance represents the bedrock upon which a psychiatrist may achieve the ultimate goal of any psychotherapy: helping the patient achieve the ability to tolerate ambivalent feelings in a relationship by developing mature higher level defense mechanisms.[5]

As the treatment progresses, the therapeutic relationship between a psychiatrist and the patient with BPD can be as similarly volatile as the patients' other significant relationships.[16] Feelings of anger or frustration toward the patient may spawn specific countertransference reactions that may include distancing, rejecting, or abandoning the patient. In addition, positive reactions may include fantasies of being the therapist who rescues or cures the patient, or romantic, sexual feelings in response to a seductive patient.[4] Proper management of these countertransference issues are best achieved through ongoing consultation with colleagues.[4] Furthermore, promoting a sense of secure attachment through frequent appointments (weekly or more frequently), communication between missed sessions or planned absences, setting limits on inappropriate or self-destructive behaviors, validation of suffering and abusive experience, helping the patient take responsibility for actions, and promotion of self reflection rather than impulsive action are key coping strategies to emphasize in the psychotherapeutic setting.[4,5]

CONCLUSION

BPD and BD symptom overlap represents a common diagnostic dilemma for psychiatrists. Carefully delineating the nature of attachments, suicidal and nonsuicidal acts, a time course of mood symptoms, role of interpersonal reactivity, and abuse history throughout childhood, adolescence, and adulthood can be especially helpful in arriving at a primary diagnosis. Chronic fears of abandonment and higher level of impulsivity, hostility, and acute suicidal threats are distinctive symptoms that can typically distinguish BPD from BD.

Aggressive pharmacologic treatment of sleep disturbance and comorbid axis I diagnoses in BPD can improve patients' outcomes when used in combination with psychotherapy as the treatment of choice. Mood stabilizers, antidepressants, and antipsychotics have all shown efficacy in reducing the impact of common symptoms particular to the heterogeneous population with BPD, namely affective instability, impulsive aggression, and identity disturbance. Of course, careful attention must be given to the potential lethality of medications utilized in the treatment of BPD.

Choosing the appropriate modality of psychotherapy for BPD should be based on the patient's core symptoms, cognitive abilities, need for guidance, ability to modulate regression, and level of psychological mindedness. Moreover, a psychiatrist must also be attuned to the acute needs of the patient as flexibility in changing the type of therapy in the midst of treatment may be necessary. Although DBT principles are specifically and effectively tailored to the hallmark symptoms of BPD, many other types of psychotherapy may be effective in reducing the severity of various BPD presentations. An accurate assessment of the patient's level of functioning, mindfulness, interpersonal effectiveness, distress tolerance, emotion regulation, and strength of social support system are key elements that will lead the clinician to institute DBT, psychodynamic psychotherapy, interpersonal, CBT, and supportive psychotherapy, either individually or in combination.

A therapeutic alliance represents the bedrock upon which a psychiatrist may achieve the ultimate goal of any psychotherapy: helping the patient achieve the ability to tolerate ambivalent feelings in a relationship by developing mature higher level defense mechanisms.[5]

Finally, building a therapeutic alliance with a patient with BPD may be a challenging task for a psychiatrist. However, understanding the common transference and countertransference reactions in a psychotherapeutic setting can equip the psychiatrist with essential foresight and knowledge to effectively facilitate the patient's movement towards more fulfilling relationships and higher level defenses.

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